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As a *telemedicine specialist* at the *Shepherd Center* in Atlanta, Georgia, I oversee the research and development of our telemedicine program. Our center is a long-term acute care hospital specializing in the treatment of individuals with spinal cord injuries, brain traumas, and multiple sclerosis (MS). We have carved our niche in telemedicine through the usage of plain old telephone system (POTS) lines, enabling us to conduct telemedicine sessions directly to one's home. While we have enhanced our patient care after discharge, we are finding that we can only accomplish a limited amount with our methods. We would like to expand our telemedicine program through partnerships with local health clinics in rural areas throughout the state of Georgia; however, cost is the biggest issue for all parties.

The most efficient method for conducting telemedicine in rural areas is through an IP-based (computer-based) system. By using the Internet, any site in a network could communicate with any other networked site through the use of a standard personal computer and an inexpensive web camera. With POTS technology, special videophones are required which can cost twice as much as a personal computer. IP-based systems require high-speed communication lines (typically a T1 line in rural areas). These lines vary widely in cost, depending on the locality. Luckily, Digital Subscriber Lines (DSL), broadband connections (via cable modems), and satellite-based systems have provided many communities with less expensive methods to access the Internet versus the cost of a T1 line; however, the overwhelming majority of these cost savings is available only in urban areas. I agree with the Commission that, "some less expensive urban services are unavailable at any price in rural areas" and heartily encourage greater incentives to companies who wish to offer high-speed communications in rural areas. This will help to increase competition among the different communication technologies, which can help keep the monthly rate at a reasonable level for a rural clinic. Finally, typical phone lines were not engineered to carry video signals. As a result, videophone connections are highly susceptible to line interference and sometimes break down when there is an incoming call to one of the parties involved in a telemedicine session. An IP-based system using high-speed communications methods are more reliable, connect individuals at a much higher speed than a videophone (closer resemblance to a television signal for observing clarity/motion, and can actually cost less money over time than a simple videophone (there would be no long distance calling charges with an IP-based system).

It is also troubling to know that there are communications providers that will raise their monthly rate (sometimes by as much as 100%) that they charge rural health providers for connection fees. Their justification pertains to a FCC rule, reiterated in its May 15, 2002 NPRM that "common carriers much charge eligible rural health care providers a rate for each supported service that is <u>no higher than the highest tariffed or</u>

publicly available commercial rate for similar service in the closest city in the state with a population of 50,000 or more people, taking distance charges into account". The carriers are aware that the government will reimburse the rural health clinics at the higher rate; however, for the rural health clinics there is typically a waiting period of 8 months between the onset of higher communication fees and receipt of government reimbursements at the higher rate. The communication companies are assuming that this process is not hurting their customers while the opposite is true. Many rural health clinics cannot financially survive for these eight months. This results in the discontinuance of telemedicine programs and the ultimate group that suffers is the patients that depend on this care the most. Paradoxically, the communication company suffers in the long run because the rural clinics, by ceasing their telemedicine operations, no longer pay any amount of money in connection fees. It is disheartening to hear of these occurrences and makes us at Shepherd Center more hesitant to expand telemedicine to the many rural areas of Georgia. To remedy this, I recommend that telecommunication companies should complete all necessary forms with the Rural Health Care Division (RHCD) within 90 days of the communications fee increase. If this step is not taken then rural health clinics should be charged their previous communications rate and there should be no increase in billing until the proper forms are filled out and the rural clinic informed that this process has been completed. If all paperwork was filled out within the 90-day window, the communications company could bill the rural health clinic at the increased rate for 90 days. After 90 days, communication companies should charge only the discounted amount to the health care site and refund the difference from the first 90 days of increased billing.

Rural health clinics are typically not high-profit institutions. To provide high-quality care to people who would not ordinarily receive it, many of these rural clinics have turned to telemedicine technologies to treat their patients. Telemedicine provides doctors and patients with greater convenience, contributes to a high standard of healthcare, and saves money for both doctor and patient. We at Shepherd Center have provided thousands of telemedicine sessions for hundreds of patients. We desire to do more; however, we are concerned by the high telecommunication costs, combined with the lack of competition in rural areas.